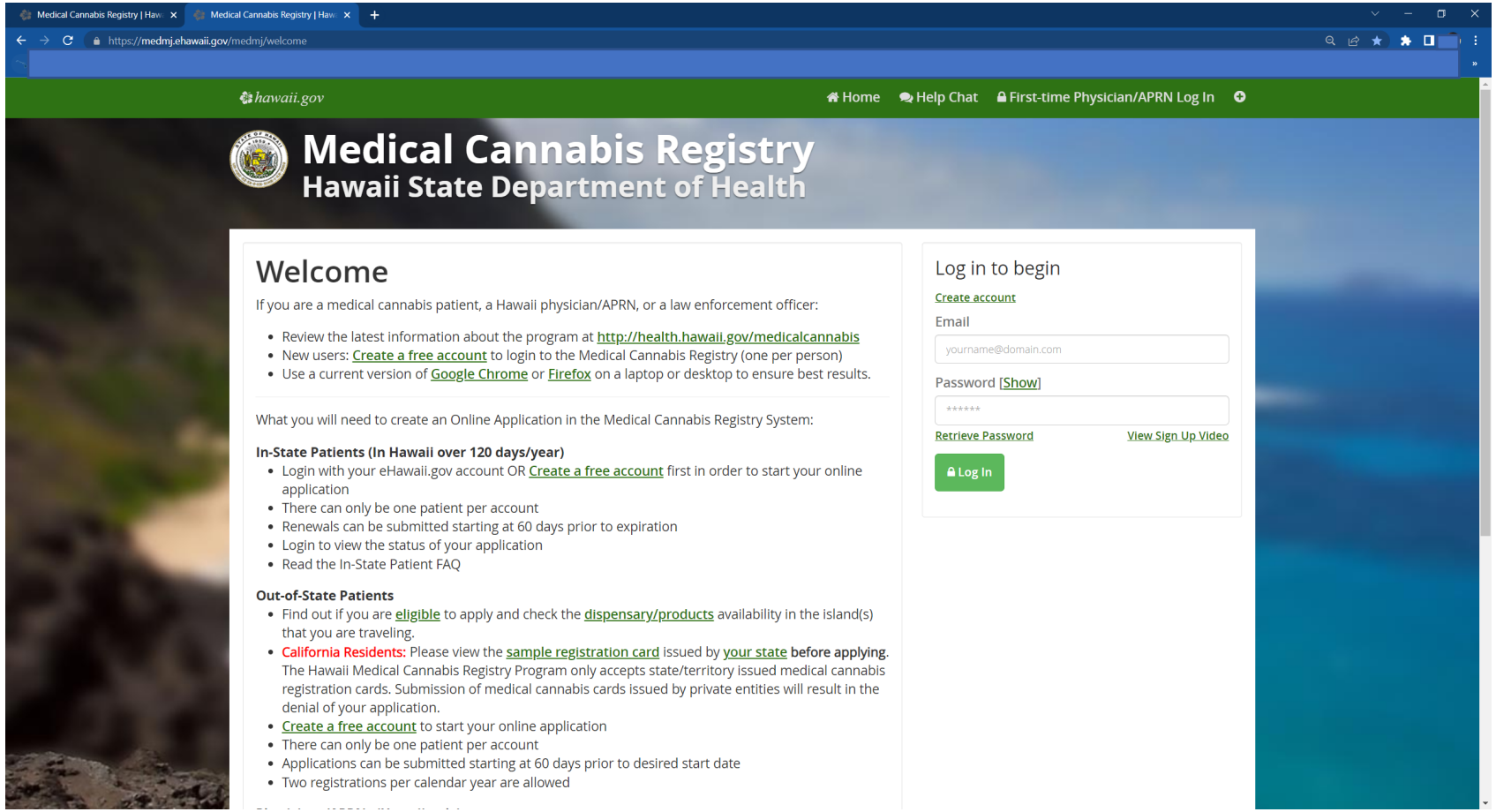
How to make changes to your 329 card online

Office of Medical Cannabis Control & Regulation

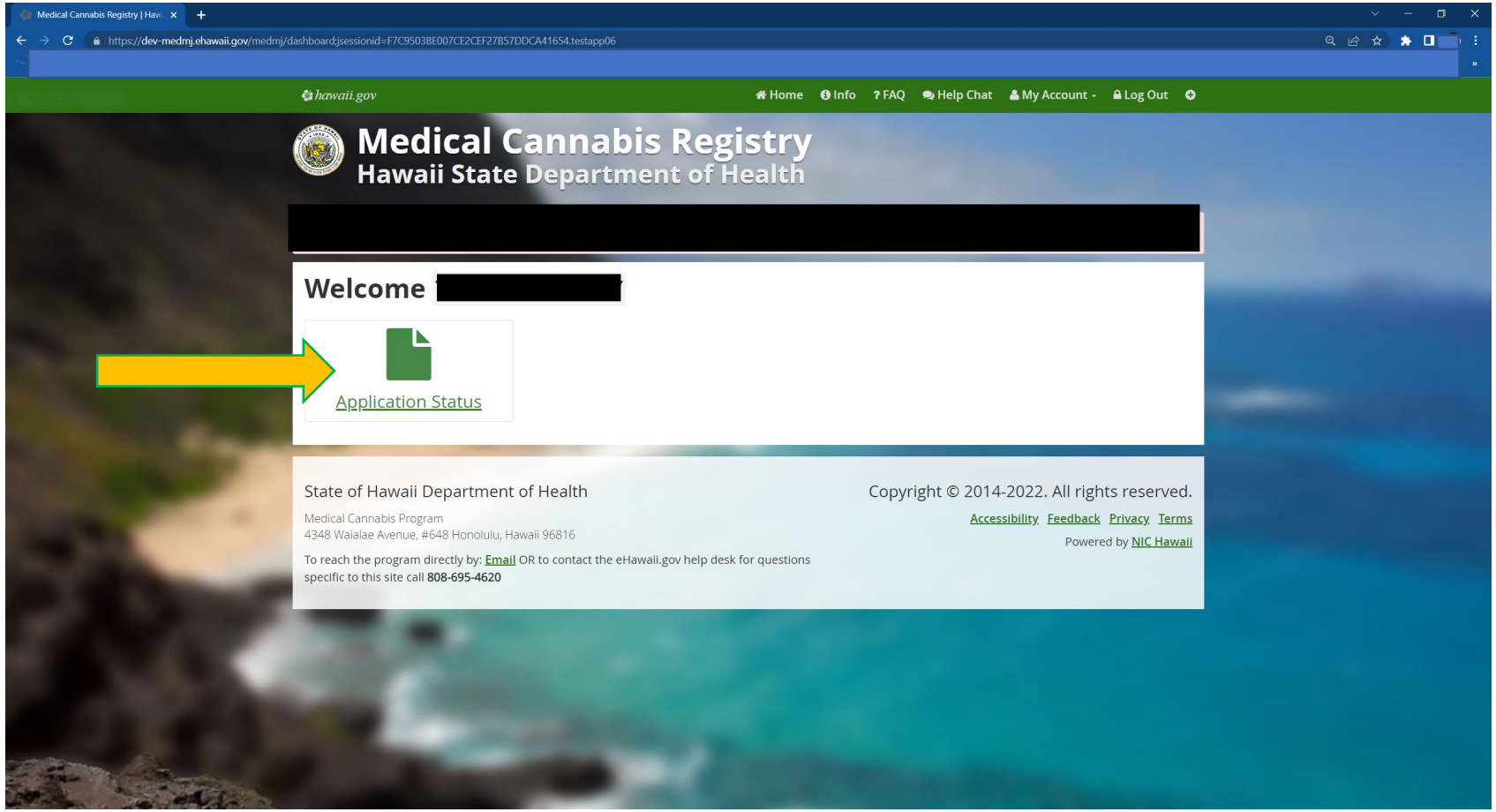
Patient Registry

2022

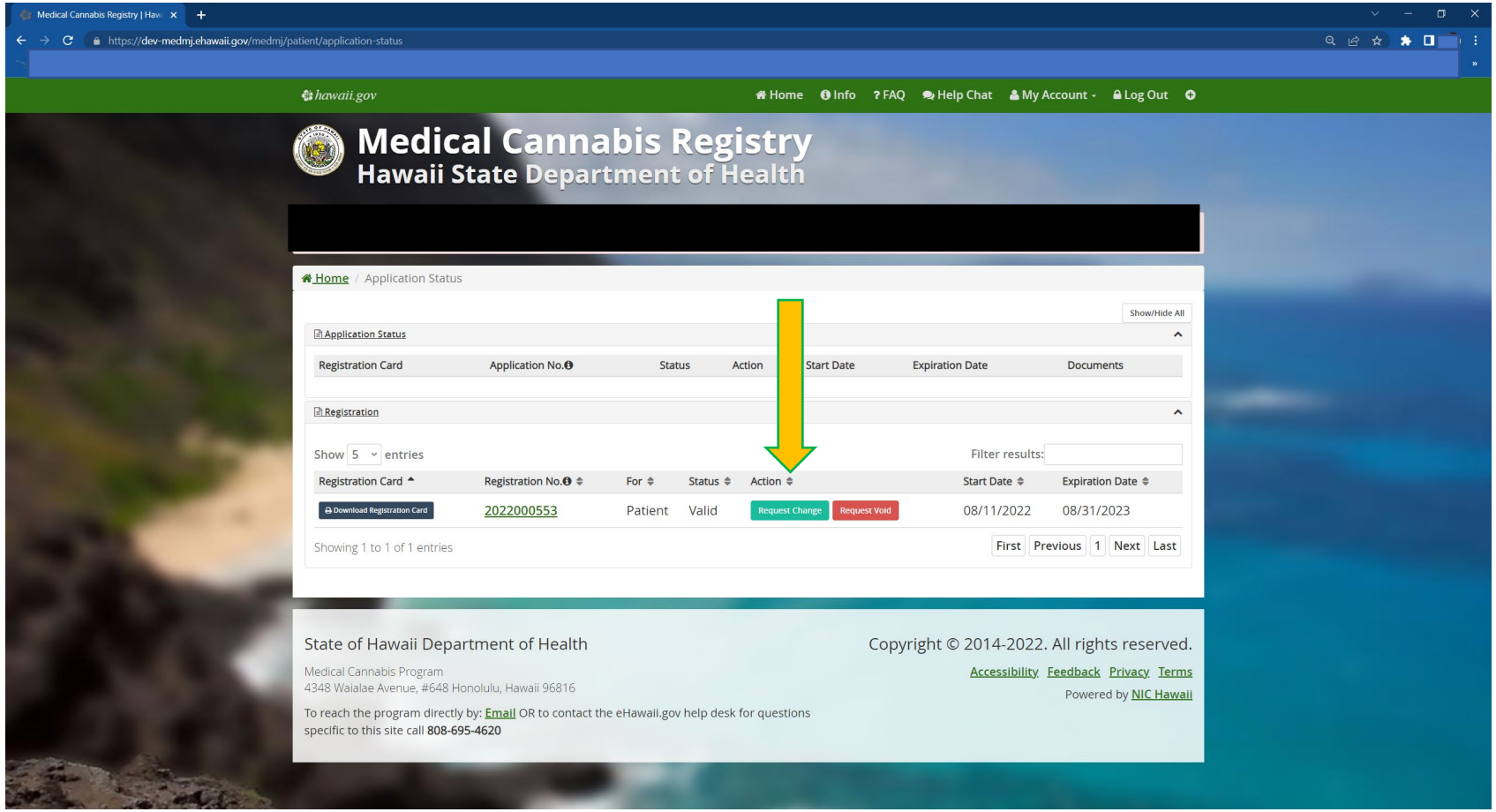
Log in to your account at https://medmj.ehawaii.gov



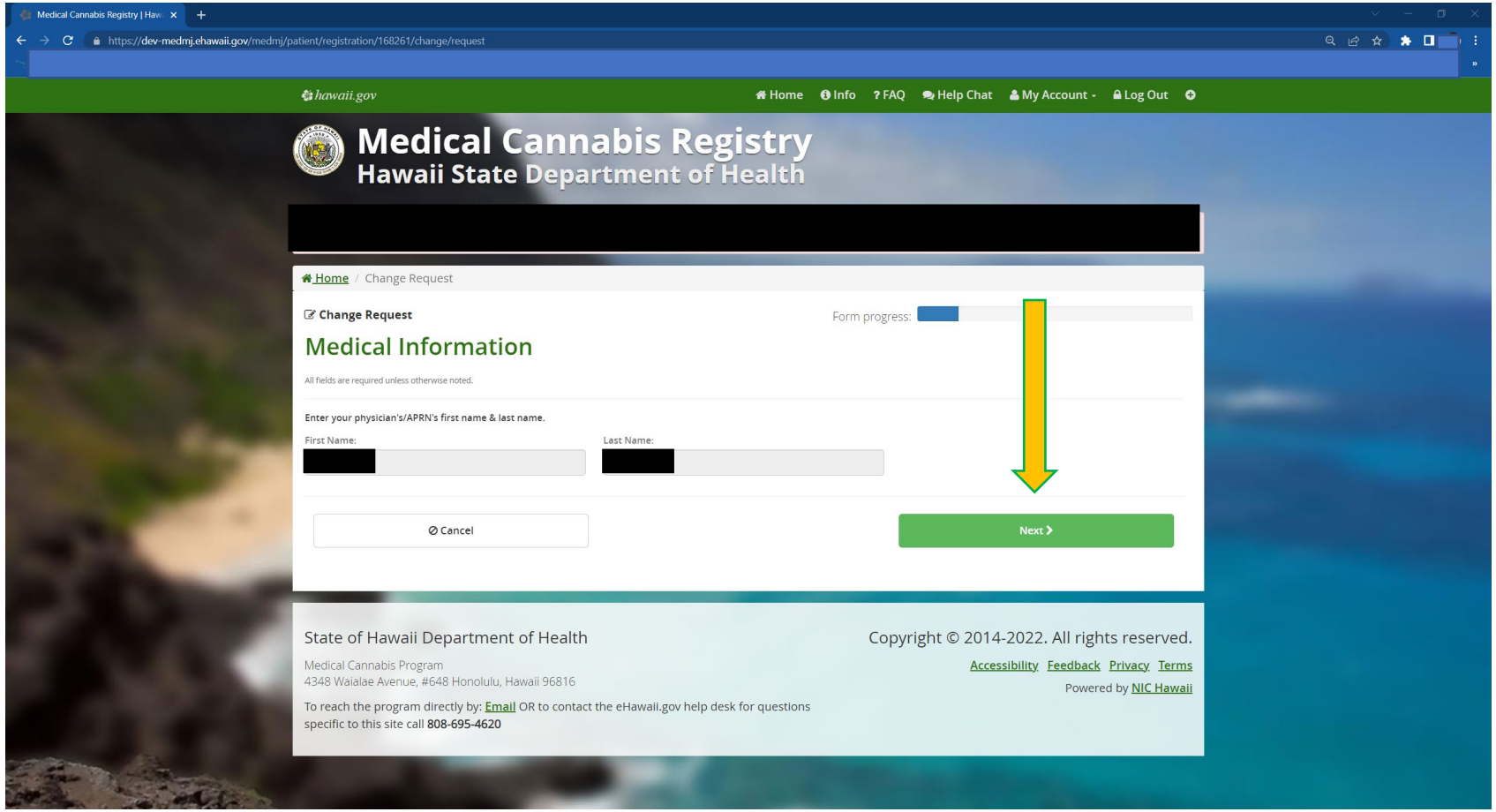
Click on “Application Status”



Select “Request Change”



Select “Next”


Medical Cannabis Registry | Haw
https://dev-medmj.ehawaii.gov/medmj/patient/registration/168261/change/request
hawaii.gov
Home
Info
FAQ
Help Chat
My Account
Log Out
Medical Cannabis Registry
Hawaii State Department of Health
[redacted]
Home / Change Request
Change Request
Form progress:
Medical Information
All fields are required unless otherwise noted.
Enter your physician's/APRN's first name & last name.
First Name:
Last Name:
Cancel
Next
State of Hawaii Department of Health
Medical Cannabis Program
4348 Waialae Avenue, #648 Honolulu, Hawaii 96816
To reach the program directly by: Email OR to contact the eHawaii.gov help desk for questions specific to this site call 808-695-4620
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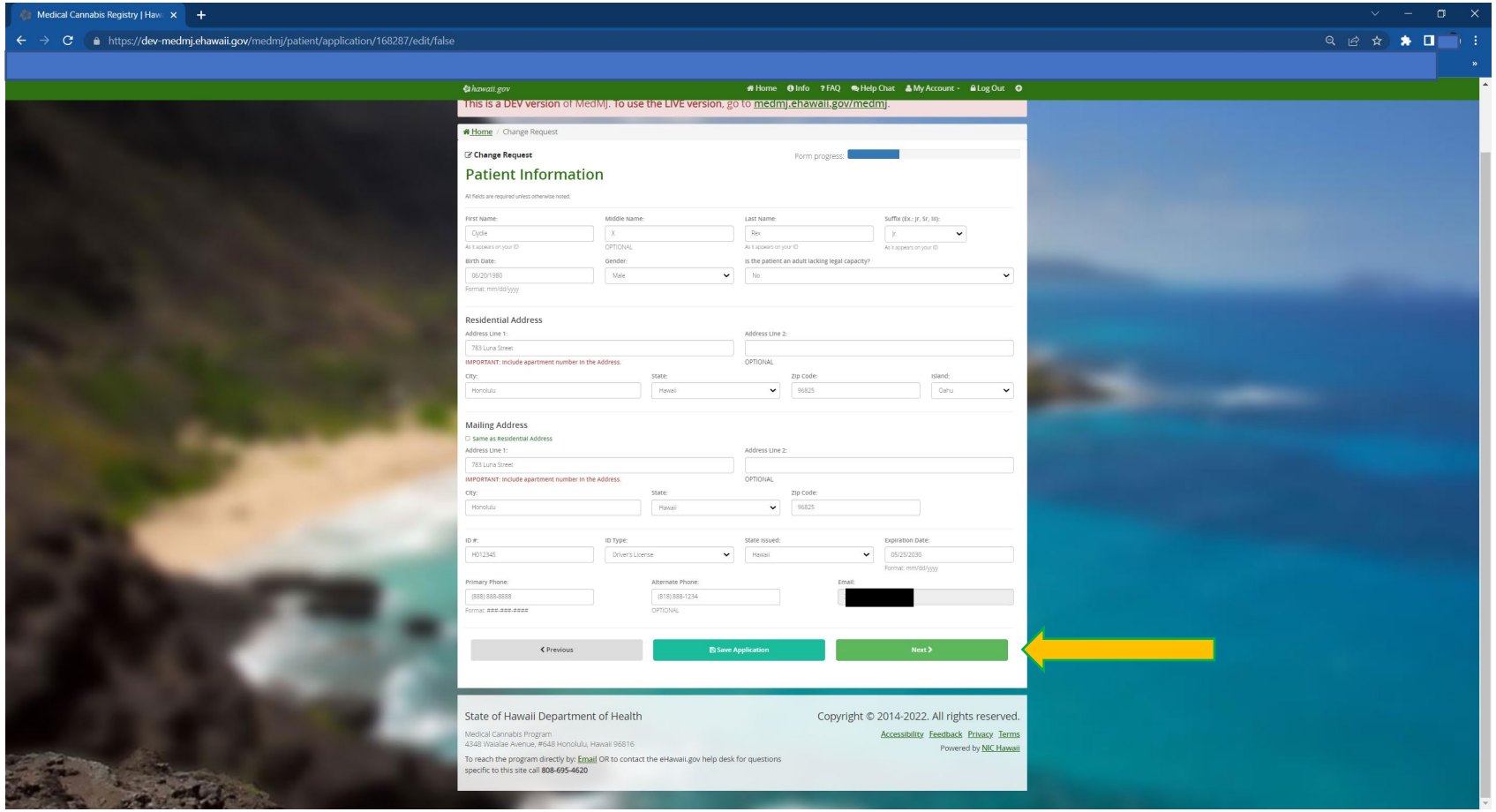
Patient Information

Make any updates to your information on this page. When you've made all the updates to this page, click next.

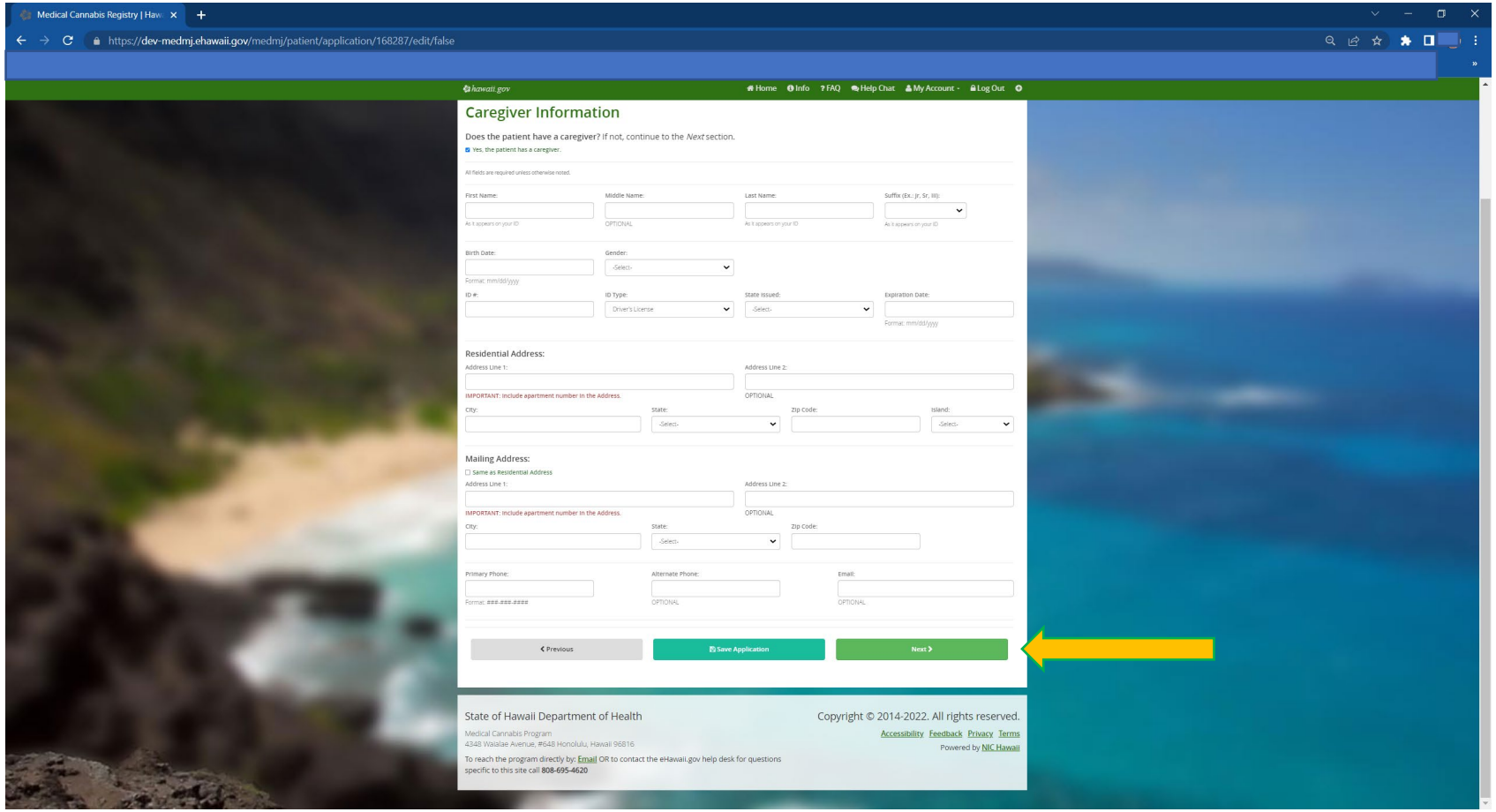


(Patient information in this document is fake and used as an example)

Caregiver Information

*If you want to add, remove, change your caregiver or update their information, please make your updates on this page and click next.

*If you don't have any updates or have a caregiver, click next.

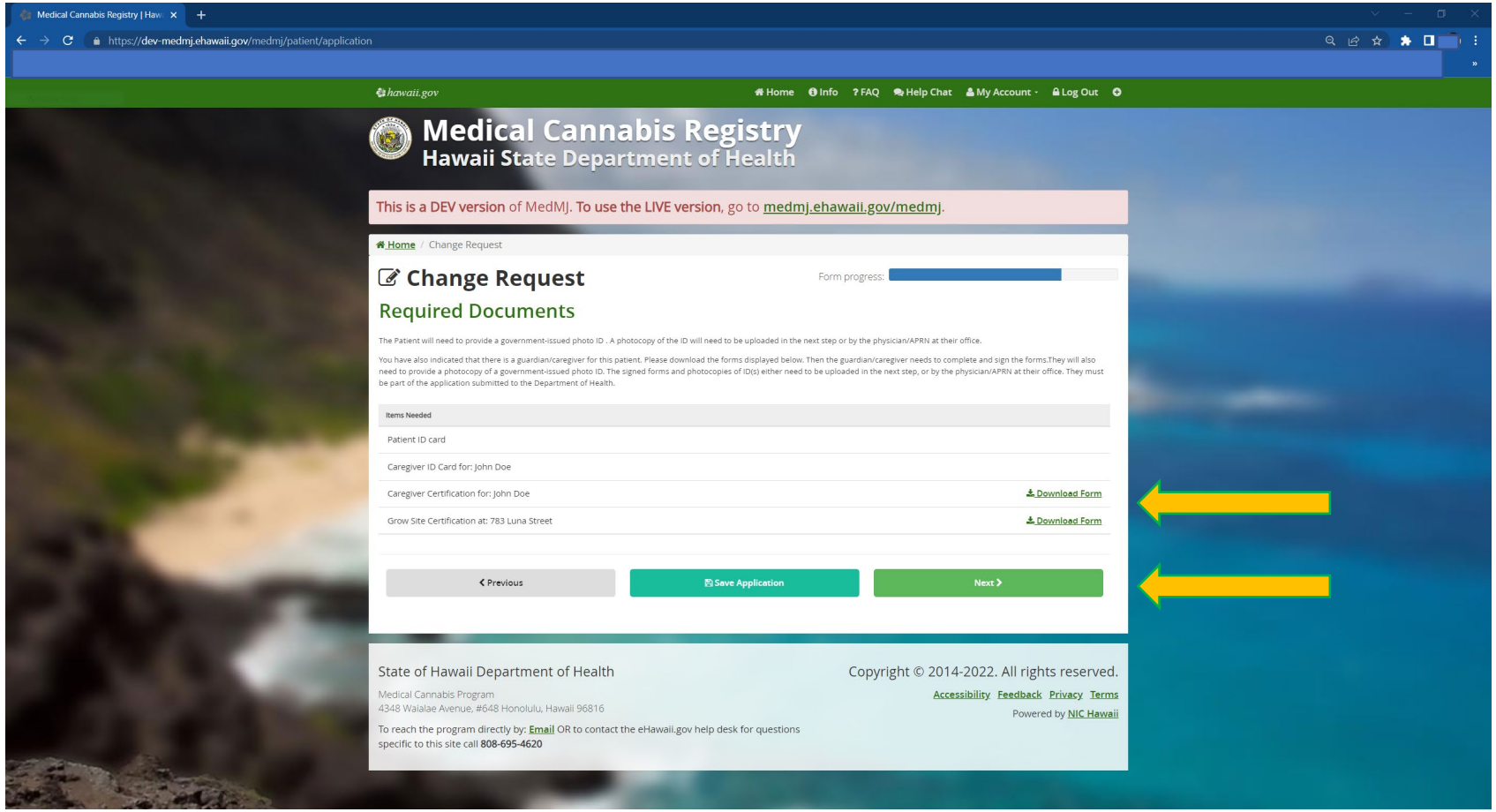


(Patient/Caregiver information in this document is fake and used as an example)

Required Documents

*If you've added or changed your caregiver information or grow site information, please download/print the forms, complete them and click next.

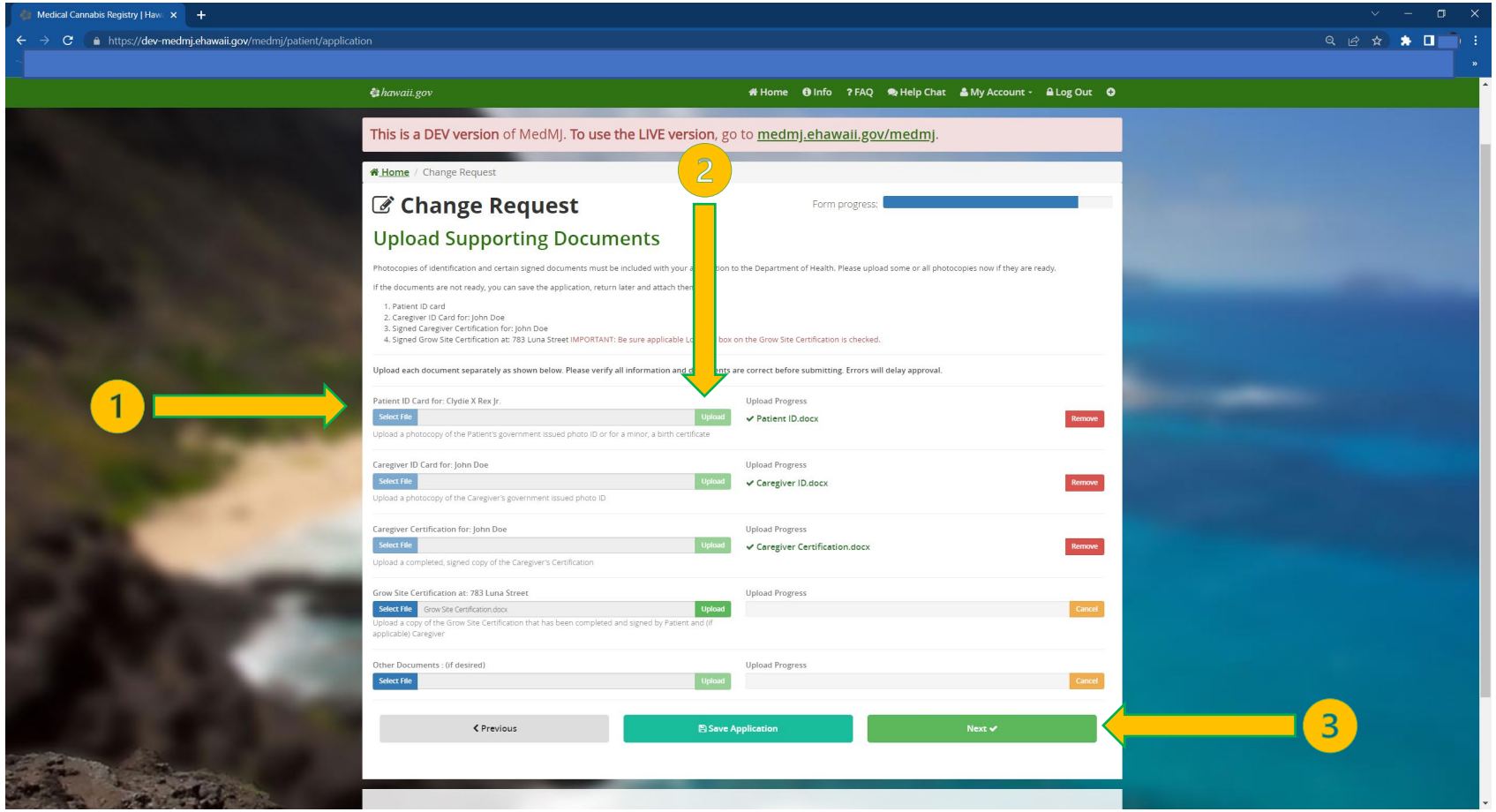
*If there is no prompt to download a form= Download Form click next.



(Patient/Caregiver information in this document is fake and used as an example)

Upload Supporting Documents

1. To upload your documents, click “select file”, find your document and click on it.
2. Next, click upload. (Repeat, as necessary)
3. Click next

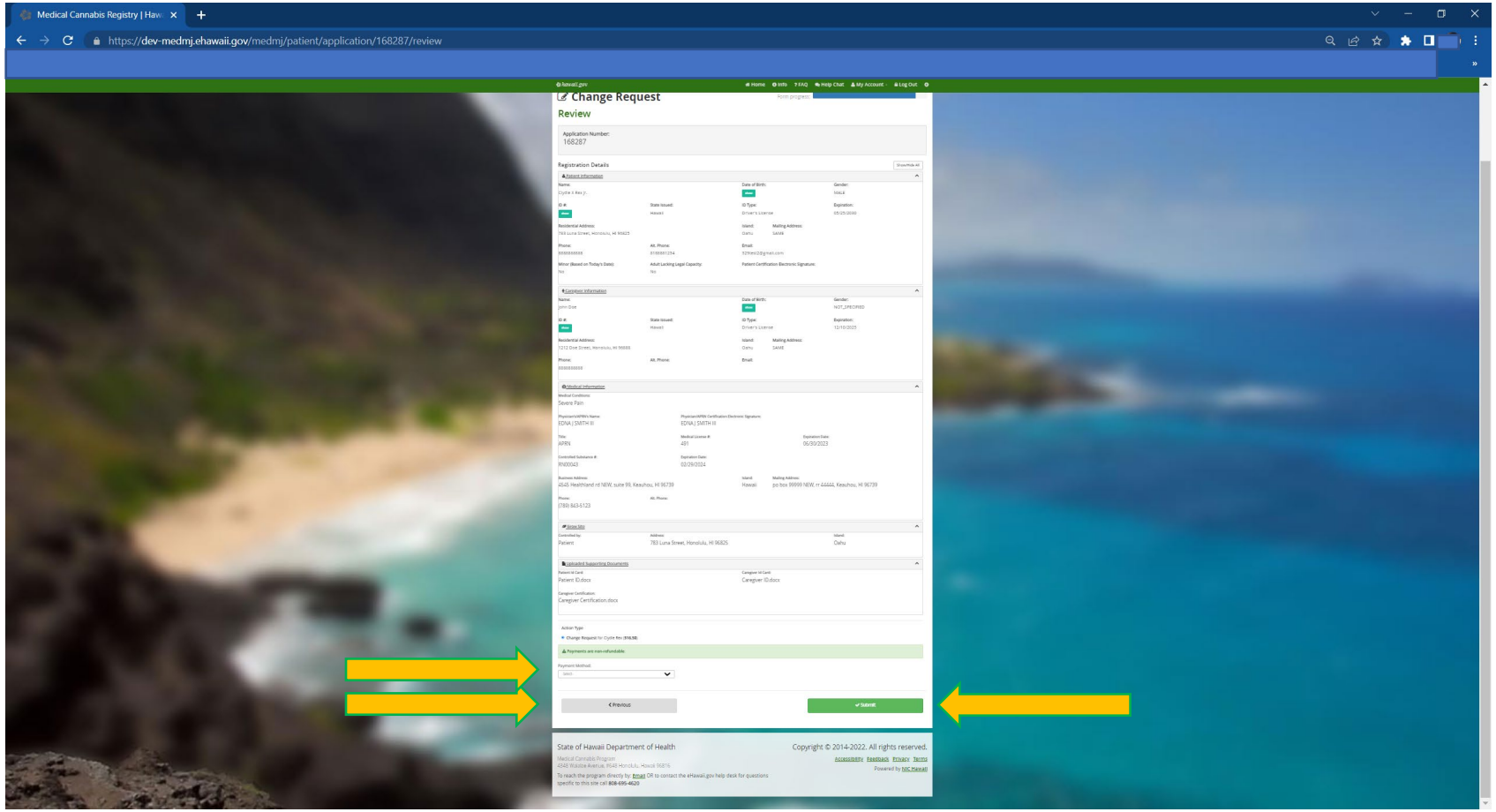


(Patient/Caregiver information in this document is fake and used as an example)

Change Request Review

Please review your information on this page. If you see any errors, click the grey “previous” button to go back to make edits.

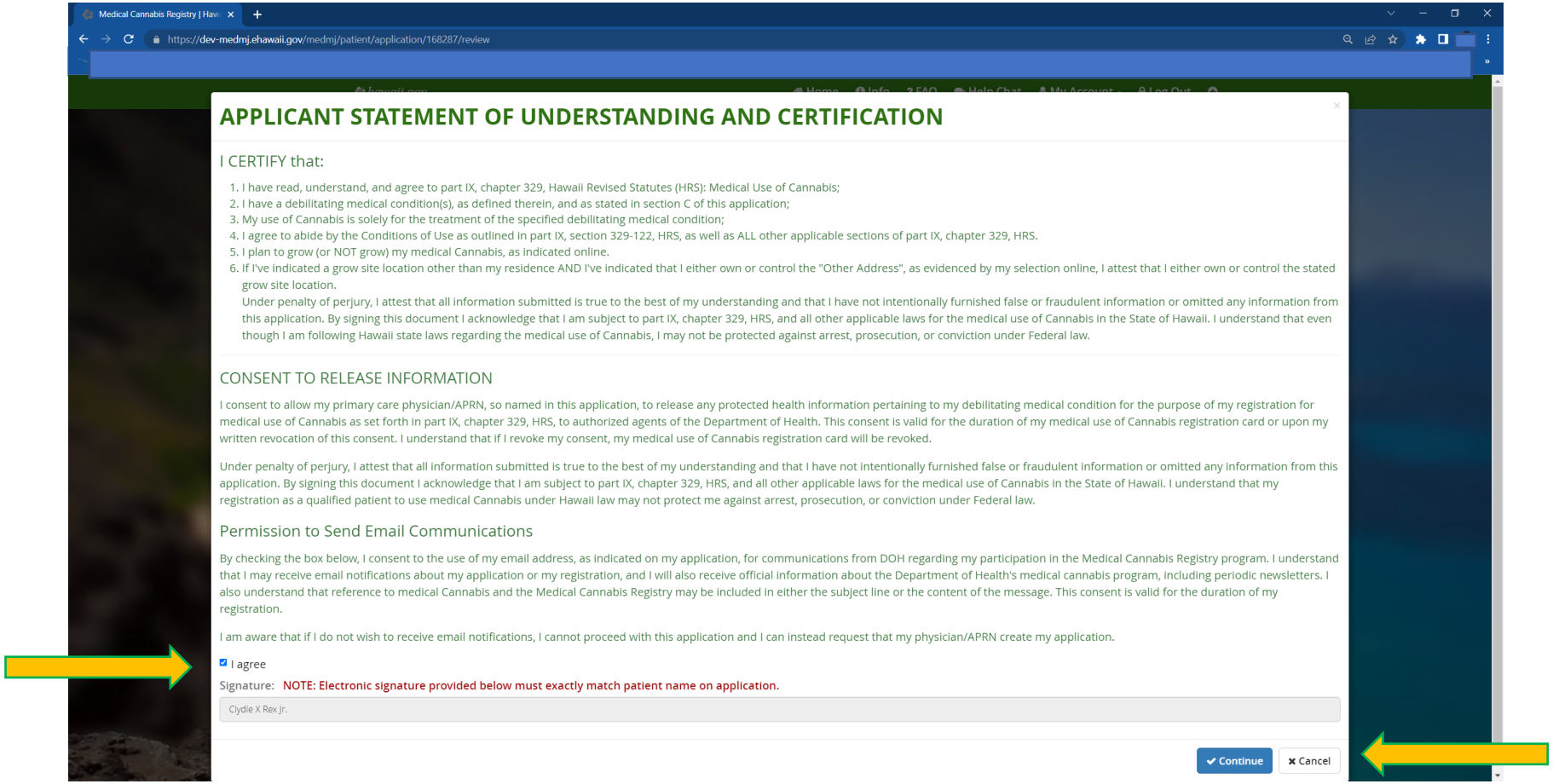
If everything is correct, select the payment method and click next.



(Patient/Caregiver information in this document is fake and used as an example)

Applicant Statement of Understanding and Certification

Please review the applicant statement of understanding and certification.
If you agree, select “I agree” and click “continue”



APPLICANT STATEMENT OF UNDERSTANDING AND CERTIFICATION

I CERTIFY that:

1. I have read, understand, and agree to part IX, chapter 329, Hawaii Revised Statutes (HRS): Medical Use of Cannabis;
2. I have a debilitating medical condition(s), as defined therein, and as stated in section C of this application;
3. My use of Cannabis is solely for the treatment of the specified debilitating medical condition;
4. I agree to abide by the Conditions of Use as outlined in part IX, section 329-122, HRS, as well as ALL other applicable sections of part IX, chapter 329, HRS.
5. I plan to grow (or NOT grow) my medical Cannabis, as indicated online.
6. If I've indicated a grow site location other than my residence AND I've indicated that I either own or control the "Other Address", as evidenced by my selection online, I attest that I either own or control the stated grow site location.

   Under penalty of perjury, I attest that all information submitted is true to the best of my understanding and that I have not intentionally furnished false or fraudulent information or omitted any information from this application. By signing this document I acknowledge that I am subject to part IX, chapter 329, HRS, and all other applicable laws for the medical use of Cannabis in the State of Hawaii. I understand that even though I am following Hawaii state laws regarding the medical use of Cannabis, I may not be protected against arrest, prosecution, or conviction under Federal law.

CONSENT TO RELEASE INFORMATION

I consent to allow my primary care physician/APRN, so named in this application, to release any protected health information pertaining to my debilitating medical condition for the purpose of my registration for medical use of Cannabis as set forth in part IX, chapter 329, HRS, to authorized agents of the Department of Health. This consent is valid for the duration of my medical use of Cannabis registration card or upon my written revocation of this consent. I understand that if I revoke my consent, my medical use of Cannabis registration card will be revoked.

Under penalty of perjury, I attest that all information submitted is true to the best of my understanding and that I have not intentionally furnished false or fraudulent information or omitted any information from this application. By signing this document I acknowledge that I am subject to part IX, chapter 329, HRS, and all other applicable laws for the medical use of Cannabis in the State of Hawaii. I understand that my registration as a qualified patient to use medical Cannabis under Hawaii law may not protect me against arrest, prosecution, or conviction under Federal law.

Permission to Send Email Communications

By checking the box below, I consent to the use of my email address, as indicated on my application, for communications from DOH regarding my participation in the Medical Cannabis Registry program. I understand that I may receive email notifications about my application or my registration, and I will also receive official information about the Department of Health's medical cannabis program, including periodic newsletters. I also understand that reference to medical Cannabis and the Medical Cannabis Registry may be included in either the subject line or the content of the message. This consent is valid for the duration of my registration.

I am aware that if I do not wish to receive email notifications, I cannot proceed with this application and I can instead request that my physician/APRN create my application.

☑ I agree

Signature: NOTE: Electronic signature provided below must exactly match patient name on application.

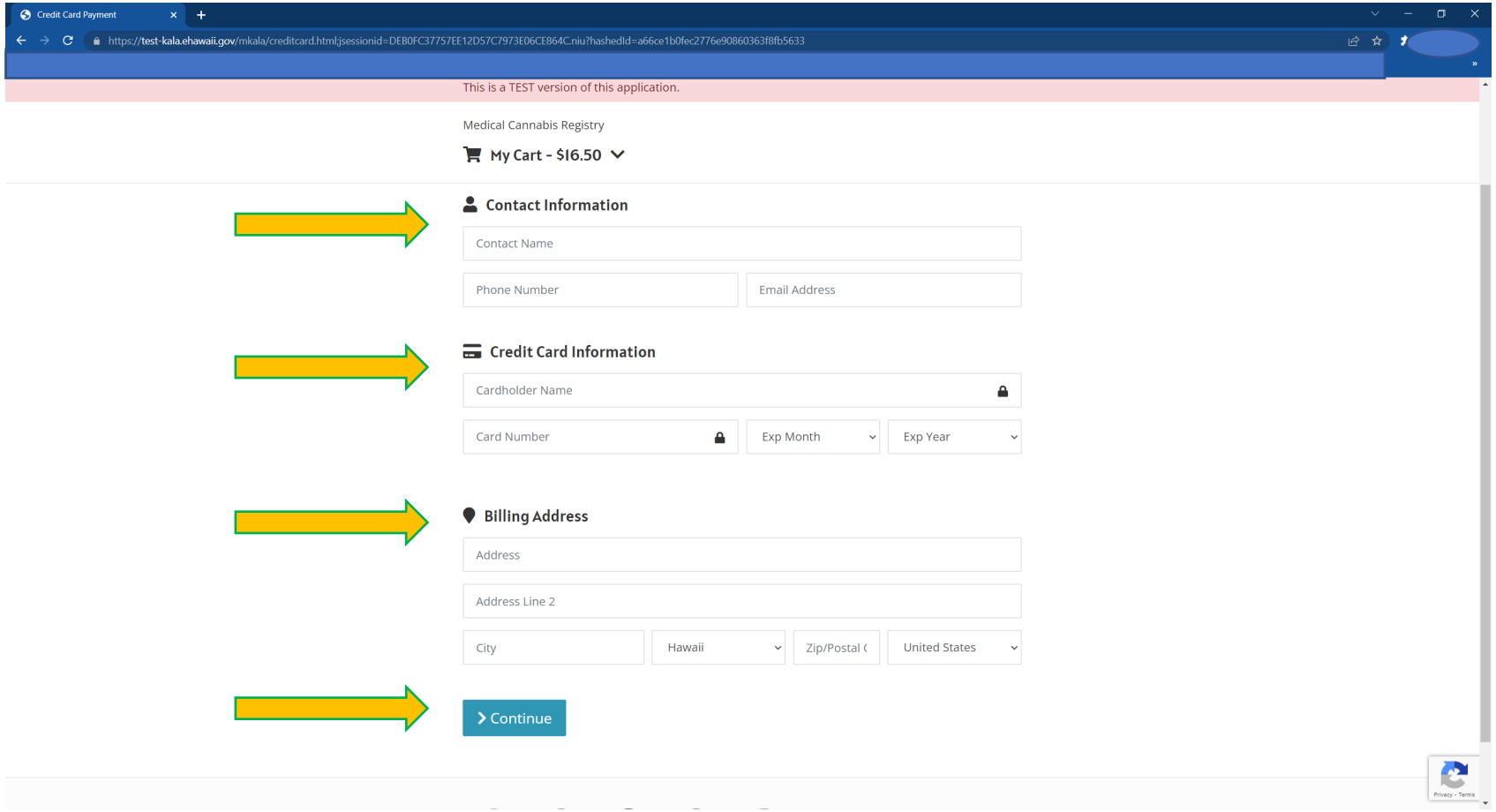
Clydie X Rex Jr.

✔ Continue ✖ Cancel

(Patient/Caregiver information in this document is fake and used as an example)

eHawaii.gov Payments

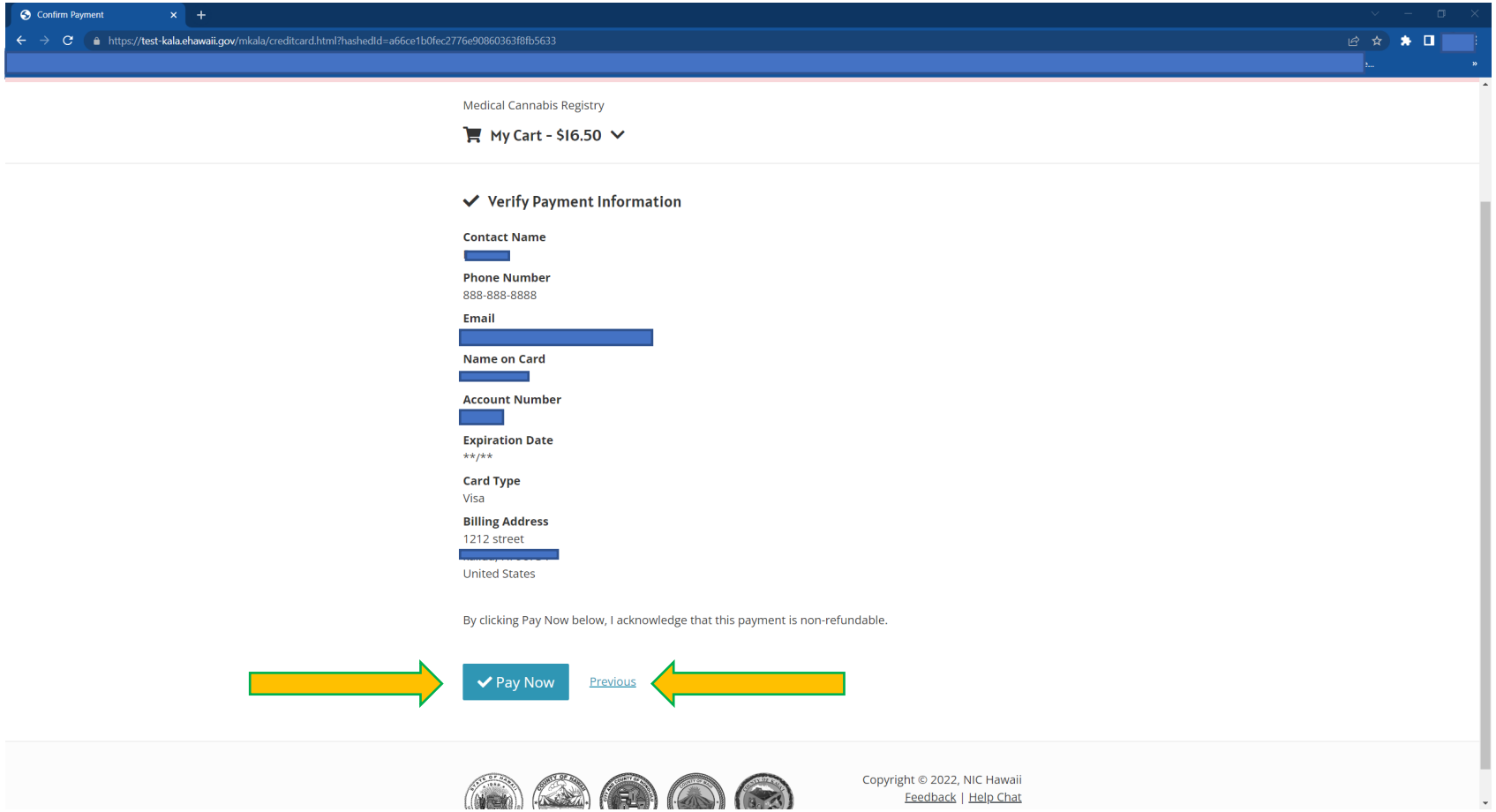
Please enter your contact information, payment information, and billing address.
If you agree, select “I agree” and click “continue”



(Patient/Caregiver information in this document is fake and used as an example)

Verify Payment Information

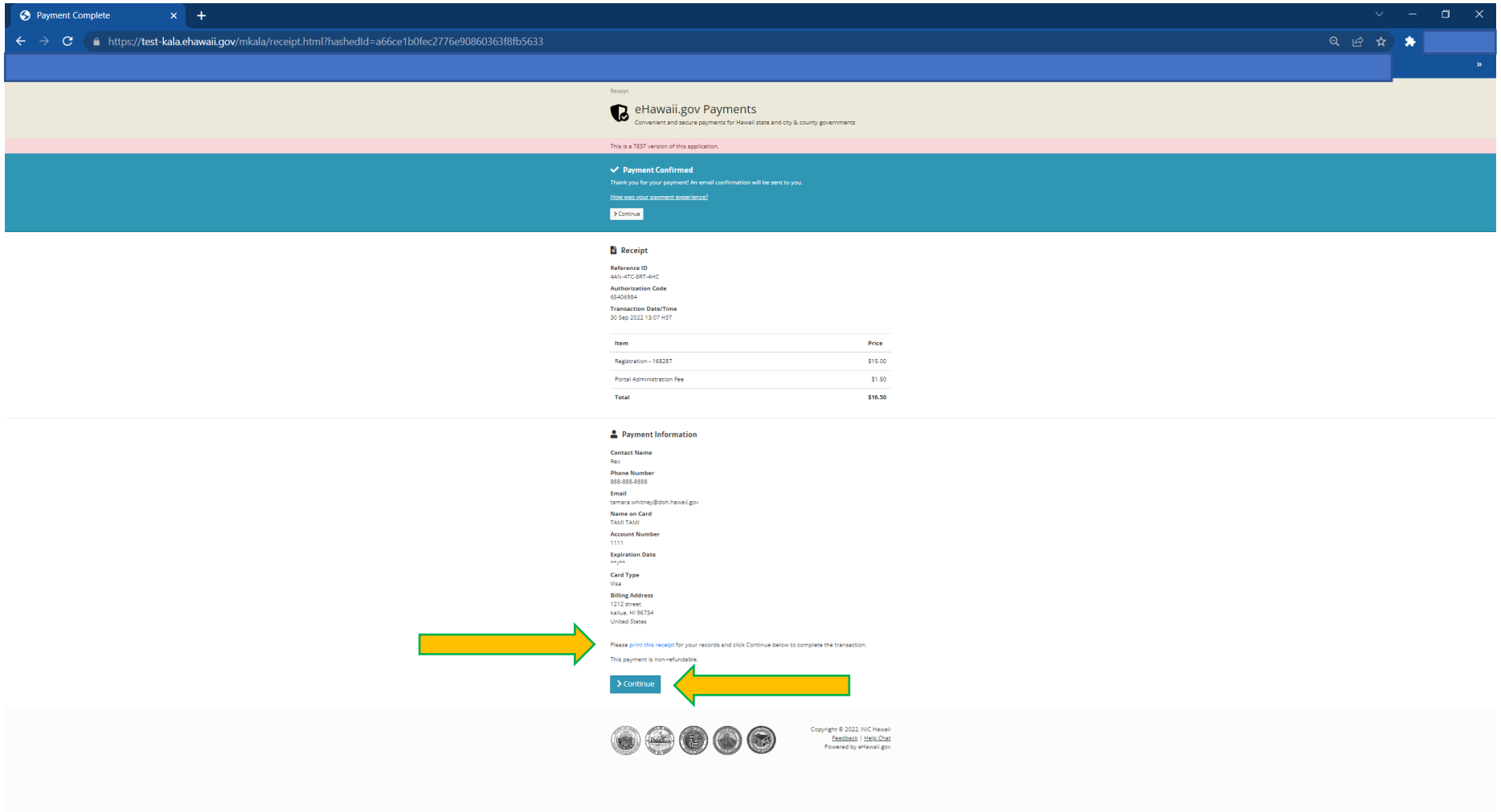
Please verify your payment information. If it is incorrect, select “previous” to edit, if it is correct, select “Pay Now”



(Patient/Caregiver information in this document is fake and used as an example)

Payment Confirmation and Receipt

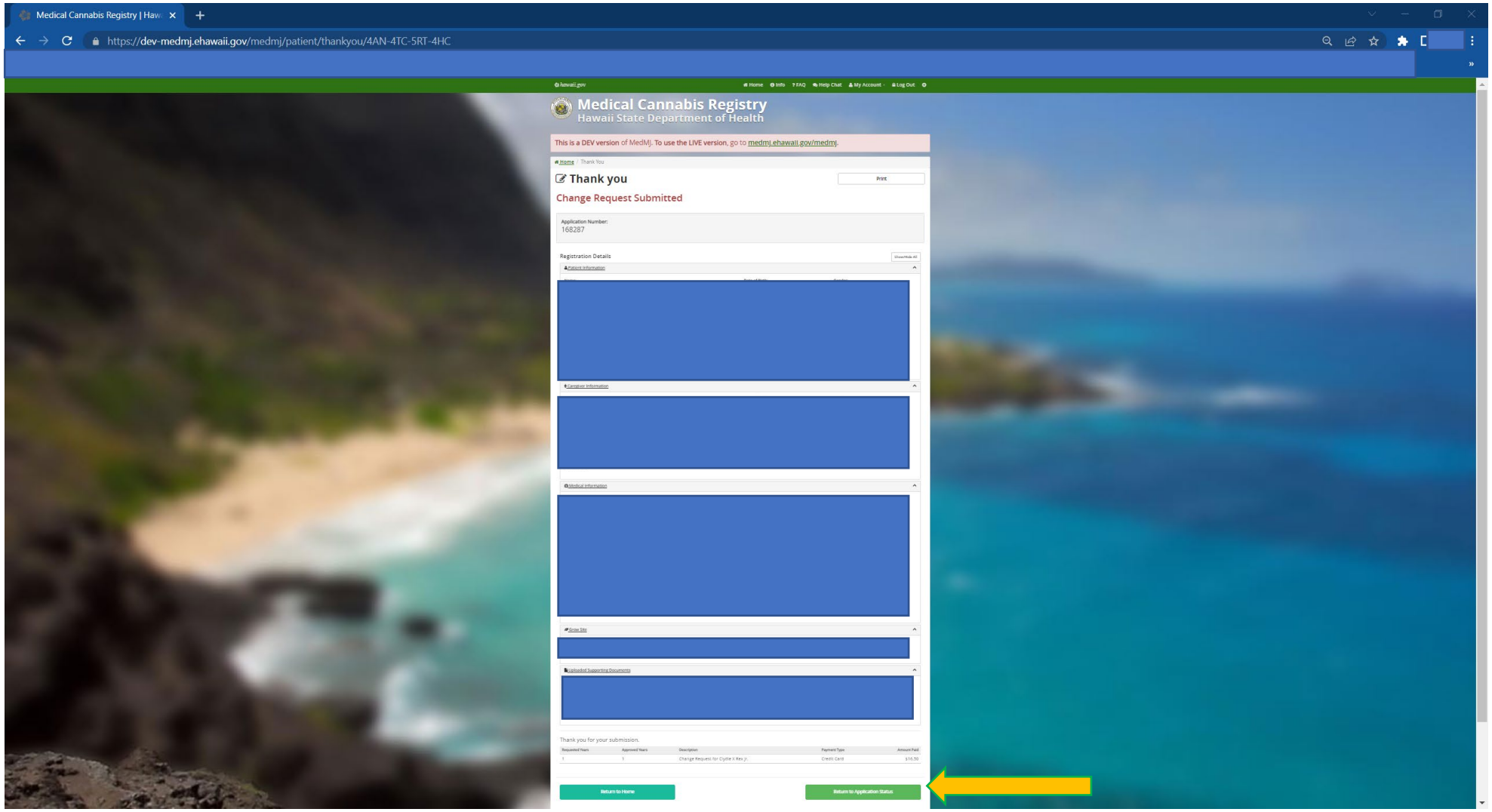
You might want to click on “print this receipt,” and print it for your records.
Next, click continue



(Patient/Caregiver information in this document is fake and used as an example)

Thank you

You have successfully submitted your change request online. Click “return to application status”



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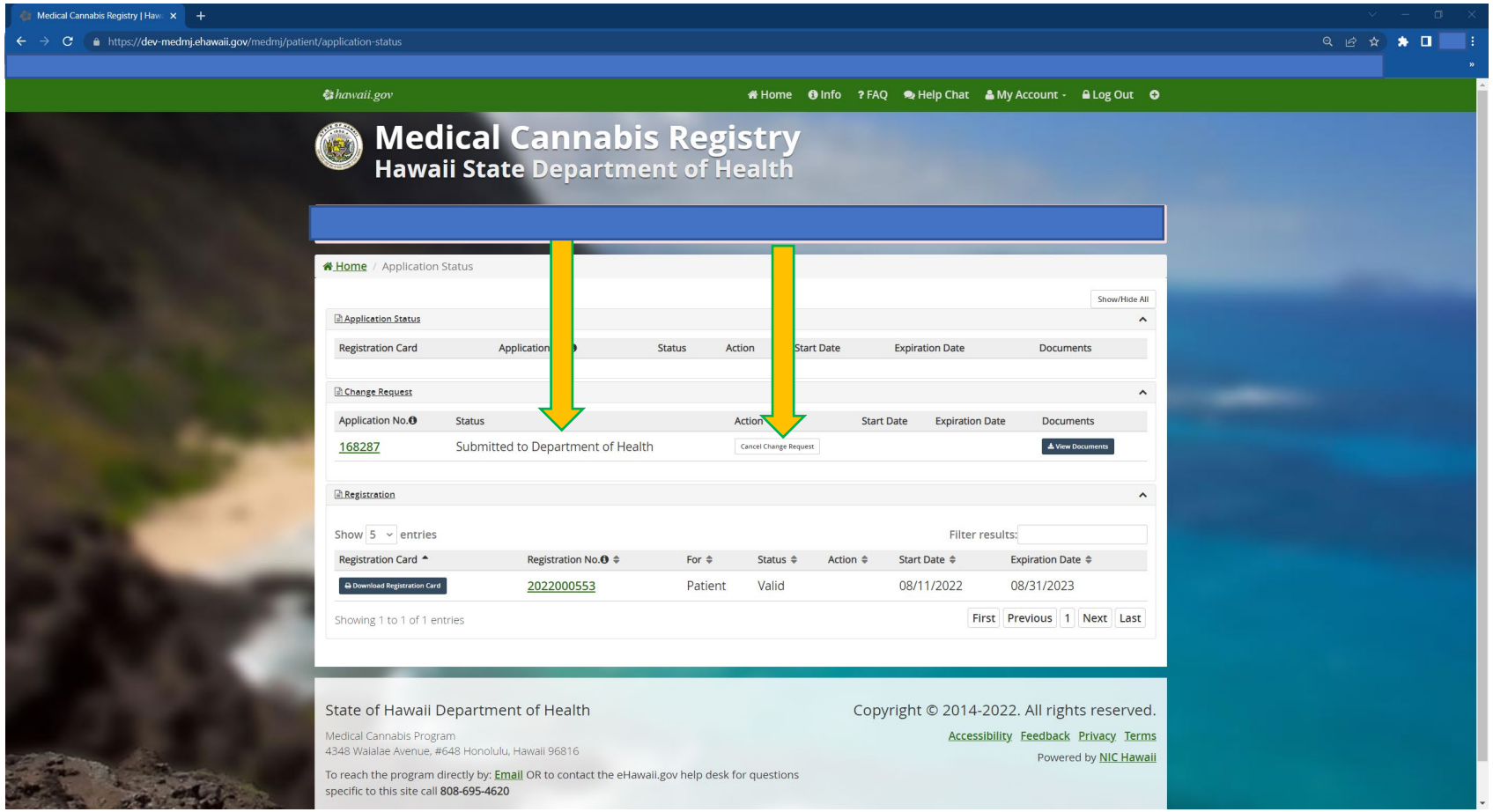
Application Status Page

Your application status should now say “submitted to Department of Health.” Please give us some time to review your request. Once your request has been approved, you will receive an email notification from us.

If you decide you no longer want the changes made, you can either contact us at medicalcannabis@doh.Hawaii.gov to return the change request to you which you may use at a later date (please provide your 6 digit application number), or you can cancel the request. **All payments are non-refundable.**



(Patient/Caregiver information in this document is fake and used as an example)

Thank you

Office of Medical Cannabis Control & Regulation

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medicalcannabis@doh.Hawaii.gov

808-733-2177

2022